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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CRAIG MARTIN MCKOWN** 512 Bret Harte Drive Copperopolis, California 95228 **Registered Nurse License No. 502272** Respondent.	Case No. 2011-671 **A C C U S A T I O N**

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 12, 1994, the Board issued Registered Nurse License Number 502272 to Craig Martin McKown ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2012, unless renewed.

STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

BACKGROUND INFORMATION

8. Between February 3, 2008, and March 31, 2008, while employed as a registered nurse at Sonora Regional Medical Center, located in Sonora, California, Respondent falsified ten (10) patients' medical records regarding glucose testing, in that Respondent falsely reported glucose levels, failed to obtain patient glucose levels, failed to document glucose levels on patient records,

failed to notify a physician of abnormal glucose levels, and failed to document intervention provided to the patients, as more particularly set forth below:

Patient 1:

a. On or about March 30, 2008, at 0638 hours, pursuant to the glucometer data log, the patient's glucose reading was 26. Respondent recorded a false glucose reading of 82 on the patient's fingerstick record, failed to notify the physician of the patient's low glucose level, failed to document the patient's low glucose reading, and failed to document any intervention provided to the patient.[1]

Patient 2:

b. On or about February 27, 2008, at 0637 hours, pursuant to the glucometer data log, the patient's glucose reading was 44. Respondent recorded a false glucose reading of 74 on the patient's fingerstick record, failed to notify the physician of the patient's low glucose level, failed to document the low glucose reading, and failed to document any intervention provided to the patient.

Patient 3:

c. On or about February 17, 2008, at 0006 hours and 0007 hours, pursuant to the glucometer data log, the patient's glucose reading was "high." Respondent failed to record the glucose reading in any hospital or patient record, failed to notify the physician of the patient's high glucose level, and failed to document any intervention provided to the patient.

d. On or about February 22, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 110 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

e. On or about March 22, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 120 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

[1] Pursuant to the governing policy for hypoglycemic management protocol, a physician must be notified when a patient's glucose level is below 60 or above 400.

f. On or about March 27, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 125 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

Patient 4:

g. On or about February 23, 2008, at 0618 hours, pursuant to the glucometer data log, the patient's glucose reading was 51. Respondent recorded a false glucose reading of 72 on the patient's fingerstick record, failed to notify the physician of the patient's low glucose level, failed to document the patient's low glucose reading, and failed to document any intervention provided to the patient.

Patient 5:

h. On or about March 26, 2008, at 0032 hours, pursuant to the glucometer data log, the patient's glucose reading was 35. Respondent recorded the patient's glucose level at 36 on the patient's fingerstick record, but failed to notify the physician of the patient's low glucose level.

i. On or about March 26, 2008, at 0130 hours, pursuant to the glucometer data log, the patient's glucose reading was 39. Respondent failed to document the patient's glucose level in any hospital or patient record, and failed to notify the physician of the patient's low glucose level.

j. On or about March 26, 2008, at 0638 hours, pursuant to the glucometer data log, the patient's glucose reading was 492. Respondent recorded a false glucose level of 250 on the patient's fingerstick record, failed to notify the physician of the patient's high glucose level, failed to document the patient's high glucose level, and failed to document any intervention provided to the patient.

Patient 6:

k. On or about March 12, 2008, at 0607 hours, pursuant to the glucometer data log, the patient's glucose reading was 43. Respondent recorded a false glucose level of 82 on the patient's fingerstick record, failed to notify the physician of the patient's low glucose level, and failed to document any intervention provided to the patient.

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Patient 7:

l. On or about March 18, 2008, at 0700 hours, Respondent recorded the patient's glucose level of 92 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

m. On or about March 22, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 125 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

n. On or about March 26, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 130 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

Patient 8:

o. On or about February 15, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 115 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

p. On or about February 22, 2008, at 0647 hours, pursuant to the glucometer data log, the patient's glucose reading was 0. Respondent recorded a false glucose level at 115 on the patient's fingerstick record.

q. On or about February 29, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 84 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

r. On or about March 3, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 98 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

s. On or about March 8, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 88 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

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t. On or about March 16, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 81 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

u. On or about March 20, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 85 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

v. On or about March 22, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 80 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

Patient 9:

w. On or about February 3, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 115 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

x. On or about February 4, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 110 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

y. On or about February 8, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 90 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

z. On or about February 9, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 105 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

Patient 10:

aa. On or about March 26, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 160 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

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bb. On or about March 27, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 176 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

cc. On or about March 28, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 160 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

dd. On or about March 30, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 150 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

ee. On or about March 31, 2008, at 0700 hours, Respondent recorded the patient's glucose level at 148 on the patient's fingerstick record when, in fact, the patient's glucose had not been taken.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that between February 3, 2008, and March 31, 2008, while employed as a registered nurse at Sonora Regional Medical Center, located in Sonora, California, Respondent was grossly negligent in the following respects:

a. Respondent documented/reported false glucose levels, as set forth above in paragraph 8, subdivisions (a), (b), (d) through (g), and (j) through (ee).

b. Respondent failed to document glucose levels on patient records, as set forth above in paragraph 8, subdivisions (c) and (i).

c. Respondent failed to notify a physician of abnormal glucose levels, as set forth above in paragraph 8, subdivisions (a), (b), (g), and (h) through (k), .

d. Respondent failed to document intervention provided to patients, as set forth above in paragraph 8, subdivisions (a) through (c), (g), (j), and (k).

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

10. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, in that between February 3, 2008, and March 31, 2008, while employed as a registered nurse at Sonora Regional Medical Center, located in Sonora, California, Respondent demonstrated unprofessional conduct, as more particularly set forth above in paragraph 8.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 502272, issued to Craig Martin McKown;

2. Ordering Craig Martin McKown to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/1/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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